3/9/10 POC accepted S. Cavanaugh HFS III

PRINTED: 02/11/20
FORM APPROVE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS773HSNF	A. BUILDING _____ B. WING _____	01/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT LANE CARE CENTER	660 DESERT LANE LAS VEGAS, NV 89106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
Z 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 01/26/10 in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. Complaint #NV00021735 was substantiated with deficiencies cited. (See Tag Z321) Complaint #NV00023977 was unsubstantiated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	Z 000	RECEIVED FEB 23 2010 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY NEVADA	
Z310 SS=D	NAC449.74493 Notification of Changes or Condition 1. A facility for skilled nursing shall immediately notify a patient, the patient's legal representative or an interested member of the patient's family, if known, and, if appropriate, the patient's physician, when: (a) The patient has been injured in an accident and may require treatment from a physician; (b) The patient's physical, mental or psychosocial health has deteriorated and resulted in medical complications or is threatening the patient's life; (c) There is a need to discontinue the current treatment of the patient because of adverse consequences caused by that treatment or to commence a new type of treatment; (d) The patient will be transferred or discharged from the facility; (e) The patient will be assigned to another room or assigned a new roommate; or (f) There is any change in federal or state law	Z310	Z310 Notification of Changes or Condition. • Resident # 1 no longer resides in the facility. • Nursing staff will be educated on notifying the Public Guardian's Office of significant change, hospitalization and change in medications and treatments. • Charts will have a visual identifier for residents with a Public Guardian.	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 2/22/10

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Z310	Continued From page 1 that affects the rights of the patient. This Regulation is not met as evidenced by: Based on record review and policy review the facility failed to notify the Public Guardian's office of a change in the resident's condition and a transfer to the hospital for Resident #1. Severity: 2 Scope: 1	Z310	• Documentation will be present in the medical record. • Audit will be done to determine compliance. • To be monitored by the DON • Completion date February 28, 2010	